Last:		First:		MID#:		Date:	

New Hampshire Medical Eligibility Determination (MED)

Assessor _____ _____ Approval Date _____
Agency/Organization _____ Phone _____

DEMOGRAPHICS

1. SSN _____-_____-_____

2. Gender: ☐ male ☐ female

3. Medicare # _____

4. DOB _____

5. Age

6. ☐ MR ☐ Serious MI

7. Mailing Address: (primary residence)
   Street _____
   City _____
   Zip _____ Phone:_____
   County _____

8. Secondary Address:
   Street _____
   City _____ Phone:_____
   Zip _____

9. Marital Status:
   ☐ 1. Never married ☐ 4. Separated
   ☐ 2. Married ☐ 5. Divorced
   ☐ 3. Widowed

10. Number in household
    (N/A if in facility) _____

11. Primary Language:
    ☐ 1. English ☐ 4. Other:
    ☐ 2. French Specify: _____
    ☐ 3. Spanish

12. Communication:
    ☐ 1. No assist necessary
    ☐ 2. Requires interpreter
    ☐ 3. Requires Asst. Device
    ☐ 4. Other: Specify _____

13. Assessment Trigger:
    ☐ 1. Service Need
    ☐ 2. Reassessment due
    ☐ 3. Significant change in condition

14. County: _____District Office _____

15. Program Requested, Start date
    HCBC-ECI: _____
    ☐ 1. Independent
    ☐ 2. Residential Care
    ☐ 3. Assisted Housing
    ☐ 4. Adult Family Home Care
    ☐ 5. Other HCBC

    Nursing Facility: _____
    ☐ 6. ICF
    ☐ 7. SNF
    ☐ 8. Swing bed ☐ ICF ☐ SNF
    ☐ 9. Atypical ☐ ICF ☐ SNF
    ☐ 10. Out of state placement

    ☐ **Private duty**

16. Location at assessment and usual place of residence:
    1. Own Home
    2. Another's Home
    3. Adult Family Home
    4. Assisted Housing
    5. Congregate Housing
    6. Homeless
    7. Hospital
    8. Hotel/Motel
    9. Nursing Facility
    10. Residential Care
    11. Other: _____

    A. Location at assessment _____
    B. Usual place of residence _____

17. Usual Living Arrangements
    Lives with (check all that apply)
    ☐ a. Alone ☐ f. w/friends
    ☐ b. w/spouse ☐ g. w/siblings
    ☐ c. w/children ☐ h. Sig. Other
    ☐ d. w/other residents ☐ i. Other:
    ☐ e. w/parents Specify _____

18. Race/Ethnicity:
    ☐ 1. American Indian/Alaskan
    ☐ 2. Asian/Pacific ☐ 5. White
    ☐ 3. Black ☐ 6. Other
    ☐ 4. Hispanic

Last:		First:		MID#:		Date:	

19. Citizenship:
- ☐ 1. U.S. Citizen
- ☐ 2. Legal alien
- ☐ 3. Other

20. Current Monthly Income Source: Applicant
- a. Earned income $_____
- b. Social Security _____
- c. Priv. Pension _____
- d. VA benefits _____
- e. SSI _____
- f. Other _____ _____
- g. Total income _____
- h. Resources _____
- i. Unknown _____

21. Medicaid Status
- ☐ 1. Not eligible
- ☐ 2. Eligible
- ☐ 3. Eligibility pending: App date ____
- ☐ 4. No application filed

22. Potential Payment Sources:
- ☐ 1. Medicare ☐ A ☐ B ☐ C ☐ D
- ☐ 2. Medicaid
- ☐ 3. Champus
- ☐ 4. VA
- ☐ 5. Title XX
- ☐ 6. Title III
- ☐ 7. Long Term Care Insurance
- ☐ 8. Other

23. Physician

Type: ☐ Primary ☐ Specialist

Name _____
Address _____
_____
Phone _____
Last visit date: _____/_____/_____

Type: ☐ Primary ☐ Specialist

Name _____
Address _____
_____
Phone _____
Last visit date: _____/_____/_____

24. Responsibility/Legal Guardian
(must have supporting documentation)
- ☐ 1. Self
- ☐ 2. Power of Attorney
- ☐ 3. Durable Power of Attorney
- ☐ 4. Durable Power of Attorney / HC Activated by Physician: ☐ YES ☐ NO
- ☐ 5. Guardian of Person
- ☐ 6. Guardian of Estate
- ☐ 7. Authorized Representative
- ☐ 8. Other _____
- ☐ 9. Unknown/Documentation unavailable

25. Key Contacts:

Name _____
Address _____
_____
Phone _____
Legal Guardian ☐ YES ☐ NO

Name _____
Address _____
_____
Phone _____
Legal Guardian ☐ YES ☐ NO

26. Advance Directives:
(only for those items with supporting documentation)
- ☐ 1. Living will
- ☐ 2. Do not resuscitate
- ☐ 3. Do not hospitalize
- ☐ 4. Organ donation
- ☐ 5. Autopsy request
- ☐ 6. Feeding restrictions
- ☐ 7. Medication restrictions
- ☐ 8. Other
- ☐ 9. Unknown/Documentation unavailable

Last:		First:		MID#:		Date:	

CLINICAL DETAIL

SECTION A. PROFESSIONAL NURSING SERVICES

Use the following codes for section A.1-A.10. (every block should be coded with a response).
Individual will need care that is or otherwise would be performed by or under the supervision of a registered professional nurse:
0. Condition/treatment not present in the last 7 days.
1. 1-2 days a week
2. 3-4 days a week
3. 5-6 days a week
4. 7 days a week
5. Once a month
6. At least once every 8 hours/7 days a week
7. Twice a month

1. INJECTIONS AND IV FEEDING		Injections/IV feeding for an unstable condition (excluding daily insulin for an individual whose diabetes is under control):
		a. Intraarterial injection
		b. Intramuscular injection
		c. Subcutaneous injection
		d. Intravenous injection
		e. Intravenous feeding (Parenteral or IV feeding)
2. FEEDING TUBE		Feeding tube for new/recent (within 30 days) or unstable condition: *Insertion date:* _____
		a. Nasogastric tube
		b. Gastrostomy tube
		c. Jejunostomy tube
3. SUCTIONING AND TRACH CARE		a. Nasopharyngeal suctioning
		b. Tracheostomy care for a new/ recent (within 30 days) or unstable condition Start date: _____
4. TREATMENTS/ DRESSINGS		Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed irrigation, application of medications, or sterile dressings and which requires the skills of an RN:
		a. Stage 3 or 4 decubitus ulcers
		b. Open surgical site
		c. 2nd or 3rd degree burns
		d. Stasis ulcer
		e. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions)
		f. Other _____
5. OXYGEN		Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) or unstable condition. *Start date:* _____

6. ASSESSMENT/ MANAGEMENT		Professional nursing assessment, observation and management required for unstable medical conditions. Observation must be needed at least once every 8 hours. Specify condition for applicant's need: _____
7. CATHETER		Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.
8. COMATOSE		Professional care is needed to manage a comatose condition.
9. VENTILATOR/ RESPIRATOR		Care is needed to manage ventilator/respirator equipment.
10. UNCONTROLLED SEIZURE DISORDER		Direct assistance from others is needed for safe management of an uncontrolled seizure disorder.
11. THERAPY/ THERAPIES PROVIDED BY A QUALIFIED THERAPIST		In the last 7 days, record the number of days each of the following therapies is anticipated/presently being received **at least 15 minutes per day** based on specific goals. (Enter 0 if none or less than 15 minutes per day.)
		a. Physical therapy
		b. Speech/language therapy
		c. Occupational therapy
		d. Respiratory therapy
12. NURSING REHABILITATION RESTORATIVE CARE		In the last 7 days, record the number of days each of the following rehabilitation or restorative techniques or practices is anticipated or presently being received **at least 15 minutes per day** based on specific goals (Enter 0 if none or less than 15 minutes per day.)
		a. Range of motion (passive)
		b. Range of motion (active)
		c. Splint or brace assistance
		TRAINING AND SKILL PRACTICE IN:
		d. Bed mobility
		e. Transfer
		f. Walking
		g. Dressing or grooming
		h. Eating or swallowing
		i. Amputation/prosthesis care
		j. Communication
		k. Other

Last:		First:		MID#:		Date:	

13. ASSESSMENT/ MANAGEMENT		Professional nursing assessment, observation and management of a medical condition: 0-Not required 3. Weekly 1-Once a month 4. Daily 2-Twice a month 5. Other: Specify: _____
		Code for applicant's need and specify condition. _____
14. PAIN/PAIN MANAGEMENT OVER THE PAST 7 DAYS		Frequency: 0- No pain 1- Less often than daily 2- Daily, but not constantly 3- All of the time
		Limitations: Interferes with activity or movement 0- No 1- Yes
		Location: _____
		Description: ☐sharp ☐dull ☐ache ☐burn ☐throb ☐other Type: ☐ Chronic ☐ Acute
		Intensity (1 – 10) _____ Is there something used that obtains relief? ☐ yes ☐no

SECTION B. SPECIAL TREATMENTS AND THERAPIES

1. TREATMENTS/ CHRONIC CONDITIONS		*Code for number of days care would be performed by or under the supervision of a registered nurse.* 0. Not required 3. Weekly 1. Once a month 4. Daily 2. Twice a month 5. Other: Specify: _____
		Professional nursing care and monitoring for administration of treatments, procedures, or dressing changes that involve prescription medications, for post-operative or chronic conditions according to physician orders.
	☐	a. Medications via tube
	☐	b Tracheostomy care–chronic stable
	☐	c. Urinary catheter change
	☐	d. Urinary catheter irrigation
	☐	e. Veni puncture by RN
	☐	f . Monthly injections
	☐	g. Barrier dressings for Stage 1 or 2 ulcers
	☐	h. Chest PT by RN
	☐	i . O2 therapy by RN for chronic unstable condition
	☐	j. Other: _____
	☐	k. Teach/train specify:_____

2. TREATMENTS/ PROCEDURES		*Code for number of days professional nursing is required.* 0. Not required 3. Weekly 1. Once a month 4. Daily 2. Twice a month 5. Other: Specify: _____
	☐	a. Chemotherapy
	☐	b. Radiation Therapy
	☐	c. Hemodialysis
	☐	d. Peritoneal Dialysis
	☐	e. IV antibiotic therapy

SECTION C. COGNITION/ORIENTATION

1. MEMORY		*(Recall of what was learned or known)* 0–Memory OK 1–Memory problems
	☐	a. Short-term memory —seems/ appears to recall after 5 minutes
	☐	b. Long-term memory — seems/ appears to recall long past
2. MEMORY/ RECALL ABILITY *(Check all that apply)*		***(Check with "x" what individual is normally able to recall during the last 7 days.** Leave remainder blank.)*
	☐	a. Current season
	☐	b. Location of own room
	☐	c. Names/faces
	☐	d. Where he/she is
	☐	e. None of the above were recalled
3. COGNITIVE SKILLS FOR DAILY DECISION MAKING		*Made decisions regarding tasks of daily life.* 0. Independent —decisions consistent/reasonable 1. Modified independence —some difficulty in new situations only 2. Moderately impaired —decisions poor; cues/supervision required 3. Severely impaired—never/rarely made decisions
4. CHANGE IN COGNITIVE STATUS		Cognitive status, skills, or abilities have changed as compared to status of 90 days ago: 0. No change 1. Improved 2. Deteriorated 3. Unable to determine
5. SPATIAL ORIENTATION		0. Oriented, able to find and keep his/her bearings. 1. Spatial confusion when driving or riding in local community. 2. Gets lost when walking neighborhood 3. Gets lost in own home or present environment.
6. ASSESSMENT/ MANAGEMENT		Are monitoring and nursing care needed to manage the identified cognitive issues: 0. No 3. Weekly 1. Once per month 4. Daily 2. Twice per month 5. Other: Specify: _____

Last:		First:		MID#:		Date:	

SECTION D. COMMUNICATION/HEARING PATTERNS

1. HEARING *(Choose only one)*		(*With hearing appliance, if used*) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED—absence of useful hearing
2. COMMUNICA-TION DEVICES/ TECHNIQUES	(*Check all that apply* ***during last 7 days.***)	
		a. Hearing aid, present and used
		b. Hearing aid, present and not used regularly
		c. Other expressive or receptive communication techniques used (e.g., lip reading).
		d. NONE OFTHE ABOVE
3. MAKING SELF UNDERSTOOD *(Choose only one)*		(*Expressing information content—however able*) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
4. ABILITY TO UNDERSTAND OTHERS *(Choose only one)*		(*Understanding information content—however able*) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS

SECTION E. VISION PATTERNS

1. VISION *(Choose only one)*		(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/ books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2. VISUAL APPLIANCES	0 – NO, 1 – YES	
		a. Glasses, contact lenses
		b. Artificial eye
		c. Braille
		d. Other: _____

SECTION F. MOOD

1. INDICATORS OF DEPRESSION ANXIETY SAD MOOD	*Code for behavior in* ***last 30 days*** *irrespective of the assumed cause.* 0. Indicator not exhibited 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
VERBAL EXPRESSIONS OF DISTRESS		a. Individual made negative statements–e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."
		b. Repetitive questions–e.g., "Where do I go? What do I do?"
		c. Repetitive verbalizations– e.g., calling out for help. ("God help me.")
		d. Persistent anger with self or others – e.g., easily annoyed; anger at placement in nursing home; anger at care received
		e. Self-deprecation–e.g., "I am nothing; I am of no use to anyone."
		f. Expressions of what appear to be unrealistic fears— e.g., fear of being abandoned, left alone, being with others
		g. Recurrent statements that something terrible is about to happen - e.g., believes he or she is about to die, have a heart attack
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
		i. Repetitive anxious complaints/ concerns (non-health related), e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues
SLEEP-CYCLE ISSUES		j. Unpleasant mood in the morning
		k. Insomnia/change in usual sleep pattern
LOSS OF INTEREST		l. Sad, pained, worried facial expressions—e.g., furrowed brows
		m. Crying, forgetfulness
		n. Repetitive physical movements, e.g., pacing, hand-wringing, restlessness, fidgeting, picking
		o. Withdrawal from activities of interest, e.g., no interest in longstanding activities or being with family/friends
		p. Reduced social interaction Individual's current mood status compared to individual's status 180 days ago.

Last:		First:		MID#:		Date:	

2. MOOD PERSISTENCE		One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console or reassure the individual over the last 7 days. 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered
3. MOOD		Individual's current mood status compared to status 180 days ago. 0. No change 1. Improved 2. Declined 3. Unable to determine

SECTION G. PROBLEM BEHAVIOR

	A	B	
1.	Frequency	Alterability	*Column A Codes: Code for the frequency of behavior as described below, 1a.-1e.* 0. Behavior of this type not exhibited 1. Behavior has occurred in past 90 days 2. Behavior has occurred 1-3 days in the last 7 days 3. Behavior occurred 4-6 days in the last 7 days but less than daily 4. Behavior of this type occurred daily *Column B codes: Alterability of behavioral symptoms* 0. Not present or easily altered 1. Behavior not easily altered
			a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety.)
			b. VERBALLY ABUSIVE (Others were threatened, screamed at, cursed at)
			c. SOCIALLY INAPPROPRIATE/ DISRUPTIVE BEHAVIOR (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)
			d. RESISTS CARE (resisted taking medications/injections, ADL assistance or eating.)
			e. MINOR PHYSICAL ABUSE (Others were shoved, pinched, or scratched, but did not result in physical injury)
			f. MAJOR PHYSICAL ABUSE (Others were hit, punched, sexually abused) resulting in bodily injury at least once in the past six months. 0 No 1 Yes
2.			Are there any safety concerns voiced by the caregiver? If so, please explain: _____ _____ _____
3.			For how many hours each day is the individual left alone?_____

4.		Are monitoring and nursing care needed to manage the identified behavioral issues? 0. No 3. Weekly 1. Once per month 4. Daily 2. Twice per month 5. Other: Specify: _____ If 3,4, or 5 is selected, please answer the supplemental questions that follow.

SECTION G.S PROBLEM BEHAVIOR SUPPLEMENT

Enter the code that most accurately describes the individual's behavior for the last 90 days, unless otherwise specified.

	1. SLEEP PATTERNS: 0. Unchanged from "normal" for the individual. 1. Sleeps noticeably more or less than "normal." 2. Restless, nightmares, disturbed sleep, increased awakenings. 3. Up wandering for all or most of the night, inability to sleep.
	2. WANDERING: 0. Does not wander. 1. Does not wander, i.e., is chair bound or bed bound. 2. Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety. 3. Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have a history of getting lost and is not combative about returning. 4. Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.
	3. BEHAVIORAL DEMANDS ON OTHERS: 0. Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions. 1. Attitudes, habits and emotional states limit the individual's type of living arrangement and companions. 2. Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The individual's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing. 3. Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The individual's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.

Last:		First:		MID#:		Date:	

4. DANGER TO SELF AND OTHERS:

0. Is not disruptive or aggressive, and is not dangerous.
1. Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).
2. Is sometimes (***1 - 3 times in the last 7 days***) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
3. Is frequently (***4 or more times during the last 7 days***) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
4. Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.
5. Has caused serious bodily harm to another in the previous 6 months.

5. AWARENESS OF NEEDS/JUDGMENT:

0. Understands those needs that must be met to maintain self-care.
1. Sometimes **(1 to 3 times in the last 7 days)** has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
2. Frequently **(4 or more times during the last 7days)** has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
3. Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

G. S TOTAL PROBLEM BEHAVIOR SCORE :

SECTION H. ENVIRONMENTAL ASSESSMENT

☐ **1.** If individual resides in a facility such as a NF, RCF, or hospital, check here and proceed to Section I.

2. HOME ENVIRONMENT

Check any of the following that makes home environment hazardous or uninhabitable.

If none apply, check NONE OF THE ABOVE.

If temporarily in institution, base assessment on home visit

- ☐ a. Lighting (including adequacy of lighting, exposed wiring)
- ☐ b. Flooring and carpeting (*e.g., holes* in floor, electric wires where individual walks, scatter rugs)
- ☐ c. Bathroom and toilet room environment (*e.g.,* non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)
- ☐ d. Kitchen environment *(e.g.,* dangerous stove, inoperative refrigerator, infestation by rodents or bugs)
- ☐ e. Heating and cooling (*e.g.,* too hot in summer, too cold in winter, wood stove in a home with an asthmatic)
- ☐ f. Personal safety *(e.g.,* fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street
- ☐ g. Access to home (*e.g.*, difficulty entering or leaving home)
- ☐ h. Access to bedroom
- ☐ I . NONE OF THE ABOVE

SECTION I. SOCIAL/COMMUNITY INFORMATION

1. TRADE OFFS *(Check all that apply)*

Because of limited funds, during the last month, individual made trade-offs in purchasing the following:

- ☐ a. Home heat
- ☐ b. Adequate food
- ☐ c. Necessary physician care
- ☐ d. Prescribed medications, devices or appliances. Describe _____
- ☐ e. Home care
- ☐ f. NONE OF THE ABOVE

2. EMPLOYMENT *(Check all that apply)*

- ☐ a. Disabled – does not work
- ☐ b. Retired – does not work
- ☐ c. Employed–remains in home
- ☐ d. Employed– outside home
- ☐ e. NONE OF THE ABOVE

3. QUALITY OF LIFE

Code as follows:
1. Daily or more often
2. 3 to 6 times per week
3. 1 to 2 times per week
4. Less than 1 time per week
5. Never

- a. Goes outside, goes for walks, enjoys nature / exercise
- b. Gets together with friends and/or attends social events
- c. Does things for personal enjoyment – e.g. reads, watches TV, plays cards
- d. Attends religious or educational activities

Last:		First:		MID#:		Date:	

4. ALCOHOL USE	*Code for behavior in **last 30 days*** 0-No 1-Yes	
		1. When talking with others, do you ever underestimate how much you actually drink?
		2. After a few drinks, have you sometimes not eaten because you didn't feel hungry?
		3. Do you drink to take your mind off your problems?
		4. Has a doctor, nurse or family member ever said they were worried or concerned about your drinking?

5. SUBSTANCE USE *Check all that apply.* If NO to all, go to section S.	USE	LEVEL
	☐ a. Caffeine	_____
	☐ b. Nicotine	_____
	☐ c. Marijuana	_____
	☐ d. Cocaine	_____
	☐ e. Crack	_____
	☐ f. Stimulants	_____
	☐ g. Inhalants	_____
	☐ h. Heroin	_____
	☐ i. Hallucinogen	_____
	☐ j. Other _____	_____
For each substance, indicate the level of use over the past 90 days, using the descriptions A through E.	A. ABSTINENT – Has not used drugs during the past 3 months	
	B. USE, BUT NO IMPAIRMENT – Has used drugs during the past 3 months, but there is no evidence of persistent or recurrent social, occupational, psychological or physical problems related to use and no evidence of recurrent dangerous use (i.e., occasional use "recreationally".)	
	C. MODERATE IMPAIRMENT – Has used drugs during the past 3 months and there is evidence of persistent or recurrent social, occupational, psychological or physical problems related to use or evidence or recurrent dangerous use (recurrent use leads to disruptive behavior. Problems have persisted for at least a month.)	
	D. SEVERE IMPAIRMENT – Meets the criteria for moderate use plus at least three of the following are present: greater amounts or intervals of use than intended; much of the personal time is used obtaining substance; frequent intoxication or withdrawal interferes with other activities; important activities are given up because of substance use; continued use despite knowledge of substance-related problems. There is marked tolerance, characteristic withdrawal symptoms, substance taken to relieve or avoid withdrawal symptoms; binges and preoccupation with alcohol/drugs have caused individual to drop out of non-drinking/drugging social activities.)	
	E. EXTREMELY SEVERE IMPAIRMENT – Meets the criteria for severe use plus related problems are so severe that they make non-institutional living difficult. (i.e. constant drug use is leading to disruptive behavior, inability to pay rent or care for self; behavior is frequently reported to the police and /or individual seeks hospitalization.	

Last:		First:		MID#:		Date:	

SECTION J. PHYSICAL FUNCTIONING/STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE

(Code for PERFORMANCE during last 7 days (24-48 hrs. if in hospital)– not including setup.)

0. INDEPENDENT — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days.
1. SUPERVISION — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus non-weight bearing physical assistance provided only 1 or 2 times during last 7 days.
2. LIMITED ASSISTANCE — Individual highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3+ times — OR — Limited assistance (as just described) plus weight bearing support 1 or 2 times during the last 7 days.
3. EXTENSIVE ASSISTANCE — While individual performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight bearing support
   — Full staff/caregiver performance during part (but not all) of last 7 days.
4. TOTAL DEPENDENCE — Full staff/caregiver performance of activity during ENTIRE 7 days.
8. ACTIVITY DID NOT OCCUR during entire 7 days.

2. ADL SUPPORT PROVIDED

(Code for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD during last 7 days (24-48 hours if individual is in hospital); code regardless of individual's self-performance classification.)

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ person physical assist
8. Activity did not occur during entire 7 days.

3. ADL CAPABILITY SOURCE OF INFORMATION

R. Reported (by individual or caregiver)
S. Seen (observed by assessor)
D. Document review

ACTIVITY	DESCRIPTION	Self performance	Support	Source
a. Bed Mobility	How individual moves to and from lying position, turns side to side, and positions body while in bed			
b. Transfers	How individual moves between surfaces — to/from: bed, chair, wheelchair, standing position **(EXCLUDE to/from bath/toilet)**			
c. Locomotion	How individual moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair			
d. Dressing	How individual puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis			
e. Eating	How individual eats and drinks (regardless of skill)			
f. Toilet Use	How individual uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes			
g. Personal Hygiene	How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum **(EXCLUDE baths and showers**)			
h. Walking	a. How individual walks within his/her personal environment			
	b. How individual navigates steps			
	c. How individual walks outside			
i. Bathing	How individual takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**EXCLUDE washing of back and hair). *(Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)*** 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity did not occur during entire 7 days			

Last:		First:		MID#:		Date:	

PRIMARY MODES OF LOCOMOTION	*Code for the primary mode of locomotion for (A) indoors and (B) outdoors from the following list:*	
		0. No assistive device
		1. Cane
		2. Walker/crutch
		3. Scooter (*e.g.* Amigo)
		4. Wheelchair
		5. Activity does not occur

SECTION K. CONTINENCE IN LAST 14 DAYS

1. BLADDER CONTINENCE *(Choose only one)*		Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants) with appliances if used (e.g., pads or incontinence program employed) in **last 14 days** 0. CONTINENT—Complete control 1. USUALLY CONTINENT — Incontinent episodes once a week or less 2. OCCASIONALLY INCONTINENT— 2 or more times a week but not daily 3. FREQUENTLY INCONTINENT— tended to be incontinent daily, but some control present 4. INCONTINENT—Bladder incontinent all (or almost all) of the time
2. BOWEL CONTINENCE *(Choose only one)*		In **last 14 days**, control of bowel movement (with appliance or bowel continence programs if employed) 0. CONTINENT—Complete control 1. USUALLY CONTINENT — Bowel incontinent episodes less than weekly 2. OCCASIONALLY INCONTINENT— Bowel incontinent episode once a week 3. FREQUENTLY INCONTINENT— Bowel incontinent episodes 2-3 times a week 4. INCONTINENT— Bowel incontinent all (or almost all) of the time, daily

3. APPLIANCES/ PROGRAMS	Support Code: 0. Independent 1. Supervision 2. Hands on person assist	Appll/ Program	Support
	a. External (condom) catheter		
	b. Indwelling catheter		
	c. Intermittent catheterization		
	d. Pads/briefs used		
	e. Ostomy present		
	f. Scheduled toileting other program		
	g . *NONE OF ABOVE*		

Last:		First:		MID#:		Date:	

SECTION L. HOME MANAGEMENT SKILLS/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. IADL SELF-PERFORMANCE CODES:

0. INDEPENDENT: (with/without assistive devices)—No help needed.
1. INDEPENDENT WITH DIFFICULTY: Individual performed task, but did so with difficulty or took a great amount of time to do so.
2. ASSISTANCE/DONE WITH HELP: Individual involved in activity, but help (including supervision, reminders, and/or physical "hands-on" help) was needed.
3. DEPENDENT/DONE BY OTHERS: Full performance of the activity was done by others The individual was not involved at all each time the activity was performed.
8. ACTIVITY DID NOT OCCUR.

2. IADL SUPPORT CODES:

0. No support needed.
1. Supervision/cueing needed.
2. Set-up help only.
3. Physical assistance needed.
4. Total dependence—the individual was not involved at all when the activity was performed.
8. Activity did not occur.

		1. Self-performance	2. Support
1. DAILY INSTRUMENTAL ACTIVITIES *Code for level of independence based on individual's involvement in the activity in **the last 7 days***	a. Meal Preparation: Prepared breakfast and light meals		
	b. Main Meal Preparation: Prepared or received main meal Meals on Wheels ____ times per week.		
	c. Telephone: Used telephone as necessary, e.g., able to contact people in an emergency.		
	d. Light Housework: Did light housework such as washing dishes, dusting (on daily basis), making own bed.		
2. OTHER INSTRUMENTAL ACTIVITIES OF DAILY LIVING *Code for level of independence based on individual's involvement in the activity in **the last 14 days***	a. Managing Finances: Managed own finances**, including banking**, handling checkbook, paying bills.		
	b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.		
	c. Grocery Shopping: Did grocery shopping as needed (excluding transportation).		
	d. Laundry: _____ Indicate: ☐ in home ☐ out of home Did laundry in home or at laundry facility (excluding transportation)		
3. TRANS-PORTATION *Check all that apply for level of independence based on individual's involvement in the activity in **the last 30 days***	☐ a. Individual drove self or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities. ☐ b. Individual needed arrangement for transportation to medical, dental appointments, necessary engagements, or other activities. ☐ c. Individual needed transportation to medical, dental appointments, necessary engagements, or other activities. ☐ d. Individual needed escort to medical, dental appointments, necessary engagements, or other activities. ☐ e. Activity did not occur.		

Last:		First:		MID#:		Date:	

SECTION M. MEDICATIONS LIST

List all medications taken and/or given during the last 7 days. Include medications used regularly less than weekly as part of the individual's treatment regimen.

1. List the medication name and the dosage

2. RA (Route of Administration). Use the appropriate code from the following list:

1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other
				11 = intrathecal

3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the medication was given.

PR = (PRN) as necessary qh= (qh) every hour q2= (q2h) every two hours q3= (q3h) every three hours q4= (q4h) every four hours q6 =(q6h) every six hours q8= (q8h) every eight hours	1D = (qd or hs) once daily 2D = (BID) two times daily (includes every 12 hours) 3D = (TID) three times daily 4D = (QID) four times daily 5D = five times a day QO = every other day	1W = (Q Week) once every week 2W = twice every week 3W = three times every week 4W = four times every week 5W = five times every week 6W = six times every week	1M = (Q Month) once every month 2M = twice every month C = continuous O = other

4. PRN-n (prn — number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

1.Medication Name and Dosage	2. RA	3. Freq	4. PRN - n	Prescribed by:
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR		

Last:		First:		MID#:		Date:	

SECTION N. MEDICATION

1a. PREPARATION/ADMINISTRATION
Did individual prepare and administer his/her own medications **in the last 7 days?** ***Check all that apply.***

- ☐ **1.** Individual required medications to be prepared daily.
- ☐ **2.** Individual required medications to be administered daily.
- ☐ **3.** Individual able to prepare medications daily.
- ☐ **4.** Individual able to administer medications daily. .
- ☐ **5.** Individual had no medications in the last 7 days.
- ☐ **6.** Facility prepares and administers medications.

1c. SELF-ADMINISTRATION
Did individual **self-administer** any of the following medications or treatments **in the last 7 days?**

- ☐ **a.** Insulin
- ☐ **b.** Oxygen
- ☐ **c.** Nebulizers
- ☐ **d.** Nitropatch
- ☐ **e.** Glucometer
- ☐ **f.** Over-the-counter Meds
- ☐ **g.** Other (specify)
- ☐ **h.** NONE OF ABOVE

1d. PRESCRIPTION DRUG MISUSE
In the past month, has the individual:

- ☐ **a.** Taken any drugs that are not prescribed
- ☐ **b.** Taken more medications than is directed by the label on the bottle
- ☐ **c.** None of the above

1b. COMPLIANCE
Individual's level of compliance with medications prescribed by a physician/psychiatrist **in the last 7 days:**

- ☐ **0.** Individual always compliant
- ☐ **1.** Individual compliant some of the time (80% of time or more often) **or** compliant with some medications
- ☐ **2.** Person rarely or never compliant
- ☐ **3.** Individual had no medications during last 7 days

1e. COMPREHENSION

- ☐ YES ☐ NO 1. Understands purpose and the schedule for medications taken
- ☐ YES ☐ NO 2. Has had medication change in the past 7 days
- ☐ YES ☐ NO 3. Need for med teaching/training

SECTION O. EXISTING KNOWN CONDITIONS

1. EXISTING KNOWN CONDITIONS: Check existing known conditions that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death. (Do not list inactive conditions.)
If none apply, CHECK item YY, NONE OF ABOVE

ENDOCRINE/METABOLIC/ NUTRITIONAL

- ☐ a. Diabetes mellitus
- ☐ b. Hyperthyroidism
- ☐ c. Hypothyroidism

HEART/CIRCULATION

- ☐ d. Arteriosclerotic heart disease (ASHD)
- ☐ e. Cardiac dysrhythmia
- ☐ f. Congestive heart failure
- ☐ g. Deep vein thrombosis
- ☐ h. Hypertension
- ☐ i. Hypotension
- ☐ j. Peripheral vascular disease
- ☐ k. Other cardiovascular disease

MUSCULOSKELETAL

- ☐ l. Arthritis
- ☐ m. Hip fracture
- ☐ n. Missing limb (e.g., amputation)
- ☐ o. Osteoporosis
- ☐ p. Pathological bone fracture

NEUROLOGICAL

- ☐ q. Alzheimer's disease
- ☐ r. Aphasia
- ☐ s. Cerebral palsy
- ☐ t. Cerebrovascular accident (stroke)
- ☐ u. Dementia other than Alzheimer's disease
- ☐ v. Hemiplegia/hemiparesis
- ☐ w. Multiple sclerosis
- ☐ x. Neuropathy
- ☐ y. Paraplegia
- ☐ z. Parkinson's disease
- ☐ aa. Quadriplegia
- ☐ bb. Seizure disorder
- ☐ cc. Transient ischemic attack (TIA)
- ☐ dd. Traumatic brain injury

PSYCHIATRIC/MOOD

- ☐ ee. Anxiety disorder
- ☐ ff. Depression
- ☐ gg. Manic depressive (bipolar)
- ☐ hh. Schizophrenia

PULMONARY

- ☐ ii. Asthma
- ☐ jj. Emphysema/COPD

SENSORY

- ☐ kk. Cataracts
- ☐ ll. Diabetic retinopathy
- ☐ mm. Glaucoma
- ☐ nn. Macular degeneration

OTHER

- ☐ oo. Allergies (specify)_____
- ☐ pp. Anemia
- ☐ qq. Cancer
- ☐ rr. Renal failure
- ☐ ss. Tuberculosis-TB
- ☐ tt. HIV
- ☐ uu. Mental retardation *(e.g.,* Down's syndrome, autism, or other organic condition related to mental retardation or developmental disability (MR/DD)
- ☐ vv. Substance abuse (alcohol or drug)
- ☐ ww. Other psychiatric diagnosis (e.g., paranoia, phobias, personality disorder)
  Specify: _____
- ☐ xx. Explicit terminal prognosis
  Specify: _____
- ☐ yy. NONE OF THE ABOVE

2. OTHER CURRENT CONDITIONS
a.
b.
c.

- ☐ **Self-report**
- ☐ **Medical Record**

Last:		First:		MID#:		Date:	

SECTION P. BALANCE

1. ACCIDENTS *(Check all that apply)*	☐ a. Fell in **past 30 days** **Number of falls in past 30 days:** _____ ☐ b. Fell in **past 31-180 days** ☐ c. Hip fracture in **last 180 days** ☐ d. Other fracture in **last 180 days** ☐ e. *NONE OF THE ABOVE*
2. FALL RISK *(Check all that apply)*	☐ a. Has unsteady gait ☐ b. Has balance problems when standing ☐ c. Limits activities because individual or family fearful of individual falling ☐ d. Furniture walking ☐ e. Environmental factors ☐ f. Non-compliant with assistive devices ☐ g. Substances or drug use as a contributing factor ☐ h. *NONE OF THE ABOVE*

SECTION Q. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION *(Check all that apply)*	☐ a. Has dentures or removable bridge ☐ b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) ☐ c. Broken, loose, or carious teeth ☐ d. Inflamed gums (gingiva), swollen or bleeding gums; oral abscesses; ulcers or rashes ☐ e. *NONE OF THE ABOVE*

SECTION R. NUTRITIONAL STATUS

1. WEIGHT *(Optional if info is not available)*	Record **weight in pounds**. Base weight on most recent measure **in last 30 days**: _____ ☐ recorded ☐ reported
2. WEIGHT CHANGE *(Optional if info is not available)*	0. No weight change 1. Unintended weight gain— 5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 2. Unintended weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 3. Intended weight loss in past year Amt_____
3. NUTRITIONAL PROBLEMS OR APPROACHES *(Check all that apply)*	☐ a. Chewing or swallowing problem ☐ b. Cannot taste and/or complains about the taste of many foods ☐ c. Regular or repetitive complaints of hunger ☐ d. Leaves 25% or more of food uneaten at most meals ☐ e. Modified diet ☐ f. Mechanically altered (or pureed) diet ☐ g. Noncompliance with diet ☐ h. Food Allergies *(specify)* _____ ☐ i. Restrictions *(specify)* _____ ☐ j. Feeding appliance: stable ☐ j1. Primary/only source of nutrition ☐ j2. Supplemental nutrition ☐ k. *NONE OF THE ABOVE*

SECTION S. SKIN CONDITIONS

1. SKIN PROBLEMS		Any troubling skin conditions or changes in the **last 180 days**? ☐ a. Abrasions (scrapes) or cuts ☐ b. Burns ☐ c. Bruises ☐ d. Rashes, itchiness, body lice, scabies ☐ e. Skin changes, ie, moles ☐ f. Skin cancer past / present ☐ g. Open sores, lesions, eczema ☐ h. Cellulitis ☐ i. *NONE OF THE ABOVE*
2. PRESSURE ULCERS		Presence of an ulcer anywhere on the body? 0 – NO, 1 – YES If "YES", identify location in space below, and indicate stage with "X". Location: _____
		Stage 1: an area of persistent skin redness.
		Stage 2: partial loss of skin
		Stage 3: skin loss – deep skin craters
		Stage 4: breaks in skin exposing muscle or bone
3. FOOT PROBLEMS *If "b" is coded "1", circle those items that apply.*		a. Individual or another person inspects feet on a regular basis? 0 – NO, 1 – YES
		b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, plantar fasciitis, nail fungus? 0 – NO 1 – YES
		c. Do foot problems interfere with: Standing 0 – NO 1 – YES
		Ambulation 0 – NO 1 – YES

Last:		First:		MID#:		Date:	

SECTION T. SUPPORT SERVICES

1. EXTENT OF HELP *(Hours of Care **Rounded)***	For instrumental and personal activities Of daily living received over the last 7 days, indicate extent of help from family, friends, and neighbors. ☐ a. Sum of time across five weekdays: _____ Hours ☐ b. Sum of time across two weekend days: _____ Hours
2. NAME OF INFORMAL SUPPORT PROVIDERS	a. Lives with individual: 0 - NO 1 - YES 2 - No such helper b. Relationship to individual: 0 - child or child-in-law 1 - Spouse 2 - Other relative 3 - Friend/Neighbor
	A. Last Name: _____ First Name: _____
	☐ Lives with individual
	☐ Relationship
	B. Last Name: _____ First Name: _____
	☐ Lives with individual
	☐ Relationship
3. CAREGIVER STATUS *(check all that apply)*	☐ a. An able and willing caregiver is available ☐ b. Primary caregiver receives help from family or friends in caring for individual ☐ c. A caregiver is unable to continue in caring activities (e.g., decline in the health of the caregiver makes it difficult to continue) ☐ d. Primary caregiver is unable to identify other helpers or unable to provide additional care should the need arise (e.g., cannot do more, other caregivers not available, or no funds to hire help) ☐ e. Primary caregiver is not satisfied with support received from family and friends (e.g., other children of individual) ☐ f. Primary caregiver expresses feelings of distress, anger or depression because of caring for individual ☐ g. NONE OF THE ABOVE

Nurses' Notes/Additional Information:

Last:		First:		MID#:		Date:	

HCBC SUPPORT PLAN **Start date:** **Stop Date:**

Informal Supports	Supports/Assistance	Provider
Medicare/Other	Service(s)	Provider

Case Management: Monthly & prn Case Manager: Agency:

National Code Description	Units	Rate	Units/ visit	Frequency	Units/ wk	Weekly Cost	Provider
HCBC Services: Independent and Assisted Housing							
Skilled Nurse	15 min	$20.73.					
Home Health Aide	15 min	$5.74					
Homemaker	15 min	$4.38					
Personal Care Services (Agency – Directed)	15 min	$4.38					
Personal Care Services (Consumer – Directed)	15 min	$4.38					
Emer. Response System	per mo.	$35.00					
Home delivered meals	per meal	$6.84					
Day Care Services (AMDC)	per day	$49.24					
In-Home Day Care	15 min	$3.45					
Respite Care Services	15 min	$1.64					
Assisted Housing	per day	$50.00					
Congregate Housing	per day	$26.00					
Home Mod per service							
Adult Family Home Care							
		Total Weekly Cost of HCBC Services			$		

HCBC Services: Residential Care	Frequency	Source
Balanced Diet		
ADL's		
IADL's		
Medication Management		
Safety		
Nursing Assessment		
Education		
Financial Management		
Transportation Arrangements		
Residential Care / per month	$2,100.00	

Total Weekly Cost: $466.67

RN signature _____